

**Wisconsin's  
Private Employer Health Care  
Purchasing Alliance**

A Report to the Legislature  
Describing Status of the Program

Private Employer Health Care Coverage Board  
and  
Office of Private Employer Health Care Coverage  
Division of Insurance Services  
Department of Employee Trust Funds

December 31, 2000

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## 1.0 INTRODUCTION

### 1.1 Report Overview

This report is submitted to comply with the legislative reporting requirement in s. 40.98(7)(a), Wis. Stats. This provision requires the Private Employer Health Care Coverage Board (hereafter referred to as the Board) to annually, on or before December 31:

*Submit a report to the appropriate standing committees under s. 13.172(3) and to the governor on the operation of the health care coverage program. The report shall specify the number of employers and employees participating in the health care coverage program, calculate the costs of the health care coverage program to employers and their employees and include recommendations for improving the health care coverage program.*

This report begins with a brief summary of the origins, placement and funding of the Private Employer Health Care Coverage Program (hereafter referred to as the PEHCCP or Program), followed by an introduction to important stakeholders and their involvement to date. The next section provides a brief overview of pooled purchasing, in general. The last section contains preliminary recommendations from the Board for increasing the likelihood of the Program's success. There is no insurance in force yet, so this report does not detail number of employers, employees or estimated costs.

### 1.2 Origins of the Private Employer Health Care Coverage Program

Establishing a voluntary health insurance purchasing pool for small businesses has been a long-standing goal of several organizations representing Wisconsin farmers and small businesses. Proposals for the State to create such a program have been before the Legislature for nearly a decade.

The legislation which created the Private Employer Health Care Coverage Program began the 1999 session as Senate Bill 1 and Assembly Bill 63, and was signed into law in October 1999 as part of the 1999-2001 biennial budget, 1999 Act 9.

### 1.3 Program Placement and Funding

Act 9 gave responsibility for the Program to the Department of Employee Trust Funds (hereafter referred to as the Department). To that end, the Department established the Office of Private Employer Health Care Coverage (hereafter referred to as the Office) in the Division of Insurance Services. This relationship presents unique opportunities and challenges. The Department is funded entirely by segregated revenue from the public employee trust fund, which, under Wisconsin trust law, may only be used for trust purposes. Therefore, the Office has established entirely separate operations: the cost of computers, printer, desks and chairs, paper, supplies, etc. must be billed to the Office budget. Department staff time (legal counsel, accounting support, and supervision, for example) must be charged back to the Office's budget.

The final legislation authorizes 3.5 full-time equivalent (FTE) positions and appropriates \$200,000 General Purpose Revenue (GPR) funding to the Department for the biennium. An additional \$200,000 allocation is designated as a grant to the Program administrator. The bill also creates an unfunded program revenue appropriation and authorizes the

Department to expend monies from this appropriation, which is to be funded by fees collected from employers participating in the Program.

As expected and despite careful budget management, current projections estimate that Office funding will be depleted by March 2001. The Department anticipates submitting a request under s. 13.10, Wis. Stats., in order to fund the Office for the remainder of the biennium. This concern is addressed in greater detail in Section 4.1, Preliminary Recommendations.

## 2.0 STRONG PARTNERSHIPS

### 2.1 Knowledgeable Board

In May 2000, Governor Tommy G. Thompson made ten of eleven appointments to the Private Employer Health Care Coverage Board. Shortly thereafter, one Board member declined his appointment due to a change in circumstances. Collectively, members of the Board bring a broad range of valuable expertise and insight. The following table presents current voting Board members and their statutory designations.

15.165(5)(a)1.	One member who represents health maintenance organizations.	<b>John Turcott</b> , former President and CEO Dean Health Plan (Madison)
15.165(5)(a)2.	One member who represents hospitals.	<b>Tim Size</b> , Executive Director Rural Wisconsin Health Coop. (Sauk City)
15.165(5)(a)3.	One member who represents insurance agents, as defined in s. 628.02(4).	<b>James Krogstad</b> , Vice President Mortenson, Matzelle & Meldrum (Madison)
15.165(5)(a)4.	Two members who are employees eligible to receive health care coverage under subch. X of ch. 40 and whose employer employs not more than 50 employees.	<b>Gina Erickson</b> , Director of Member Services Employers Health Cooperative (Janesville) <b>Vacant Seat</b>
15.165(5)(a)5.	One member who represents insurers.	<b>DeWayne Bierman</b> , President T.I.C., Inc. (Onalaska)
15.165(5)(a)6.	Two members who are, or who represent, employers that employ not more than 50 employees and who are eligible to offer health care coverage under subch. X of ch. 40.	<b>James Janes</b> , President Oshkosh Marine Supply Co. (Oshkosh) <b>Christopher Queram</b> , CEO The Alliance (Madison)
15.165(5)(a)7.	One member who is a physician, as defined in s. 448.01(5).	<b>Vacant Seat</b>
15.165(5)(a)8.	Two members who represent the public interest.	<b>Kenneth Conger</b> , retired (Kohler) <b>Gary Meier</b> , President Metalworld, Inc. (Racine)

In addition, the Secretary of Employee Trust Funds and the Secretary of Health and Family Services serve on the Board as non-voting members.

The Board first met on August 23, 2000, to organize, review its statutory responsibilities, and discuss the results of staff activities to date. The Board has since met twice: on November 2, 2000 and December 4, 2000. In addition to Board members and staff of the Office and the Department, Board meetings have been well attended by representatives of small businesses, farms, insurers, health maintenance organizations (HMOs), preferred provider organizations (PPOs), insurance agencies, legislative and other government offices, and other interested parties.

Minutes of the Board's meetings are available from Gina Fischer, 608-266-1652 or [gina.fischer@etf.state.wi.us](mailto:gina.fischer@etf.state.wi.us).

## **2.2 Agents and Health Plans**

In October, the Office hosted an informal meeting with a small group of insurance agents from geographically diverse areas of the state to solicit their input as the basic framework of the Program is established. Staff sought information about the current state of the private-sector insurance market and the climate in which insurers and employers operate. The group's insights proved extremely valuable. Those in attendance agreed to continue working together as the Program takes shape.

In coming weeks, Office staff will meet with health plan representatives to gauge their level of interest in participating in the Program. Current best-selling medical benefit plan designs have been gathered from Wisconsin's top small-group insurers. Additional information about medical underwriting and rating practices, agent/broker relationships, and other important areas of interest will be sought. This data will guide development of benefit plan designs and other Program features.

## **2.3 Community Support**

The Office has been working with a variety of organizations representing Wisconsin businesses—Chambers of Commerce, Wisconsin Independent Businesses (WIB), the Wisconsin chapter of the National Federation of Independent Business (NFIB), the Wisconsin Farm Bureau Federation, and Wisconsin Manufacturers and Commerce—to distribute a survey regarding health insurance issues.

The questionnaire was based, in part, on a subset of questions contained in the “OCI Survey on Small Employer Health Insurance,” a cooperative effort of the Office of the Commissioner of Insurance (OCI) and NFIB. The second page of that survey, the results of which were presented in the spring of 1995, gauged employer awareness of and reaction to the basic benefit plan. Office staff modified the 1994 survey to include questions specific to the Program.

Of 9,000 surveys distributed by WIB to its top contributors, 943 have been returned (for a response rate of 10.48%). Of these, 876 were completed correctly (9.73% of those distributed). The Office has also received 243 surveys (201 completed correctly) which were distributed through individual Chambers of Commerce. Because the survey was sent to all Chambers, without a requirement that Chambers report whether or to how many employers they distributed it, response rates cannot be determined. In addition, some surveys have not yet been distributed, so responses will continue to arrive through the end of the year.

Some caution should be exercised in interpreting the results of this survey. This survey is only an indication of the demographic profile and opinions of employers who are members of the distributing organizations. A similar survey of employers statewide, conducted using statistically valid sampling methods, might produce different results.

Preliminary results of this survey, based on approximately 900 valid survey responses received by mid-October, were shared with the Board at its November 2 meeting. Specific points of interest are summarized below.

- Sixty-nine percent of respondents provide health insurance, while 31 percent do not.
- Among insuring respondents, the number of hours an employee must work to be eligible for insurance varies considerably. The average requirement is 33.5 hours and the median is 32.0 hours.
- Among insuring respondents, the top three reasons for selecting a given health plan are:
  - Broadest choice of physicians/hospitals
  - Low deductibles/co-payments
  - Low employer share of premium
- When asked to place an employee-choice program among these rankings, over half of insuring respondents ranked it among their top four considerations.
- Among non-insuring respondents, the top three reasons for not insuring are:
  - Too expensive for my business
  - Too expensive for my employees
  - Business not profitable enough
- Among non-insuring respondents, 79 percent have never offered health insurance to their employees, 38 percent are very likely or more likely than not to offer health insurance in the next two years, and 24 percent don't know if they will offer health insurance within that timeframe.
- Nearly 80 percent of respondents have been in business 10 years or longer.
- Almost half of respondents (47 percent) pay an average hourly wage of \$10.01-15.00.

Final results are expected in early 2001. With the results, Office staff expect to identify key insurance issues facing these employers and gauge statewide interest in the Program. This information will also aid in negotiations with the Program administrator and interested insurance carriers.

In addition to the insights they shared, the speed with which respondents returned the questionnaire demonstrates the ability of participating organizations to mobilize a large number of small employers quickly, and provides yet another measure of the importance of these issues to the small business community. The pledge of these same organizations to offer their assistance in marketing the Program to their members will be invaluable.

## **2.4 Identifying an Administrator**

As directed by Act 9, the Office initiated a procurement process to select a vendor to serve as the backbone of the Program, by:

- contracting with health plans;
- conducting enrollment and dual-choice periods (during which enrollees may change their health plan selections);
- maintaining eligibility files;
- billing, collecting and distributing premium;
- providing agent training and support;

- producing reports about Program performance; and
- developing and implementing a comprehensive marketing and public relations campaign to increase awareness of the Program statewide, or subcontracting these services.

Given the importance of these services to the success of the Program, careful attention has been paid to developing the Request for Proposals (RFP). Office staff have consulted with the Institute for Health Policy Solutions (IHPS), a Washington DC-based non-profit organization with particular interest and expertise in employee-choice health purchasing arrangements, to ensure that the criteria by which proposals are evaluated are consistent with successful efforts in other states. The Office of the Commissioner of Insurance and Department of Health and Family Services have also been consulted.

The Office hosted a procurement briefing for interested vendors in advance of releasing the RFP, to provide background about the procurement, solicit input about the process, and facilitate introductions between potential out-of-state administrators and Wisconsin advertising/public relations firms. A draft of the RFP was circulated to interested administrative vendors for comment before its final release on November 13, 2000.

Proposals were due December 5, 2000. Despite indications from prospective vendors that the RFP would attract interest, no proposals were received by the deadline. The Department is carefully evaluating how best to proceed.

## **2.5 Coordinating with Other Programs for the Uninsured**

To maximize the potential for the PEHCCP to serve the uninsured, specific research and consulting services were built into a State Planning Grant submitted by the Department of Health and Family Services (DHFS). Wisconsin was awarded a total of \$1,349,846, a small portion of which will be used to compensate the Institute for Health Policy Solutions for their assistance in the PEHCCP's development and implementation. The State Planning Grants program, administered by the U.S. Department of Health and Human Services' Health Resources and Services Administration (HRSA), is designed to generate innovative models for covering the uninsured.

Office and DHFS staff are meeting regularly to build an understanding of the inter-relationships between the PEHCCP and private sector insurance, on the one hand, and BadgerCare and other public-sector programs, on the other. These discussions and relationships hold great promise.

## 3.0 POOLED PURCHASING: A BRIEF INTRODUCTION

### 3.1 Expectations of Pooled Purchasing

Since the early 1990s, voluntary purchasing pools like the one envisioned by PEHCCP supporters have been an important component of several states' efforts to improve the health insurance options of small employers. The expectations of such arrangements are often broad and far-reaching. They include:

- administrative simplicity;
- choice of multiple insurers and benefit packages; and
- leverage in negotiating lower premiums.

Recent research indicates that existing purchasing pools have been successful in offering two of these advantages—administrative services and a range of benefit options to small employers. Specifically, pools have been able to provide a single point of entry for employee choice of plans offered by multiple insurers.<sup>1</sup> Employee choice of health plans becomes more important as managed care plans penetrate the health care market, when being in one plan rather than another can affect an employee's choice of providers, style and level of service, and quality of care. Being able to offer employees a choice of plans is seen as a significant benefit by both employers and employees.<sup>2</sup> (See preliminary survey results presented in Section 2.3 for one measure of the employer's perspective.) Presenting health plan options to their employees has assisted participating employers in their recruitment and retention efforts and creates a better likelihood that their employees are able to select a plan that includes the provider of their choice.<sup>3</sup> Purchasing pools provide a vehicle for offering employees this choice.

Pools cannot, however, create a choice of health plans where none currently exists. The Office anticipates gathering existing health insurance options together under the PEHCCP to offer employee choice among those options. The current availability of health plan choice differs around the state. In fact, options under the Department's program for state employees are limited in many areas (see map in Attachment A, from "It's Your Choice 2001," provided to state employees). The availability of employee choice under the PEHCCP is unlikely to exceed the level currently offered to state employees.

In general pools have typically *not* been permitted to leverage the negotiating power of these small firms to reduce insurance premiums or, if they have been permitted to do so, their success has been short-lived. The U.S. General Accounting Office cites three reasons for limited success in this area:

- "[purchasing pools] lack sufficient leverage as a result of their limited market share;
- the cooperatives have not been able to produce administrative cost savings for insurers; or

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<sup>1</sup> Cooperatives Offer Small Employers Plan Choice and Market Prices, U.S. General Accounting Office, March 2000.

<sup>2</sup> Small Employer Health Insurance Purchasing Arrangements: Can They Expand Coverage? Elliot K. Wicks, Ph.D. and Jack A. Meyer, Ph.D., New Directions for Policy, May 1999

<sup>3</sup> U.S. General Accounting Office, March 2000

- their state laws and regulations already restrict to differing degrees the amount insurers can vary the premiums charged different groups purchasing the same health plan.”<sup>4</sup>

### 3.2 “Pooled Purchasing” vs. “Pooling Risk”

A recent report on the “Barriers to Small-Group Purchasing Cooperatives” expresses the distinction between “pooled purchasing” and “pooled risk” quite succinctly:

*“...it is important to correct one common misperception. HPC-like arrangements [health insurance purchasing cooperatives] are often referred to as pooled purchasing arrangements, which, of course, they are in the sense that employers purchase coverage collectively. But some people incorrectly deduce from this terminology that HPCs can realize savings by pooling risks—for example, by accepting higher-risk groups, combining them with average-risk and below-average-risk groups, and then charging them all essentially the same rate. This has sometimes been proposed as a way a HPC could reduce premiums for high-risk groups. But the fact is that, if, in rating each group in a pool, a HPC voluntarily decides or is required to apply rules that are significantly more permissive than those used by insurers offering coverage outside the HPC, the HPC will become a victim of adverse selection.”<sup>5</sup>*

Based on the experience of unsuccessful purchasing pools in Texas, Florida, North Carolina and elsewhere, the movement has developed a paradigm: “Mirror your market.” In short, this statement cautions that rating and participation rules inside a purchasing pool must be aligned, as much as possible, with rules in the outside market, to protect insurers and the pool itself.

Thus, bringing small businesses together to purchase a product unavailable to each individually (employee choice of health plans) is a recipe for success. Doing so with less restrictive participation requirements, underwriting guidelines or rating rules than exist in the outside market would put the Program at significant risk of failure.

### 3.3 Lessons From California

In asking the Legislature to pass a law creating the PEHCCP, supporters relied in large part on a similar program, the Health Insurance Plan of California (HIPC), formed in 1993. By most accounts, the HIPC has achieved success: at least initially, it achieved premium savings for participants, although that advantage has not held up over time; it has brought health plan choice to hundreds of thousands of employees of small businesses; and it has arguably increased health plan options outside the HIPC, as well. The HIPC was successfully privatized in 1999 and is now known as Pacific Health Advantage (PacAdvantage).

In October, Office staff interviewed key personnel at the Managed Risk Medical Insurance Board (MRMIB), the state agency responsible for the HIPC when it was a state-run entity, and the Pacific Business Group on Health (PBGH), which oversees PacAdvantage, to learn from their experience. MRMIB and PBGH staff were asked to identify components

<sup>4</sup> U.S. General Accounting Office, March 2000

<sup>5</sup> Barriers to Small-Group Purchasing Cooperatives, Elliot K. Wicks, Mark A. Hall & Jack A. Meyer, Economic and Social Research Institute, March 2000

of their program they felt contributed to its success, areas in which they have made changes in response to the market, and choices they would make differently, given the knowledge they have today. Their advice can be summarized as follows:

- Cultivate relationships with agents and brokers, invest in resources to make selling the Program simple for them, and ensure that they are compensated fairly. They are an important link to the small business community.
- Strike a balance when developing standardized benefit plan designs. Plans with low cost-sharing and rich benefits will be too expensive for many, while plans with limited benefits will not appeal to others.
- Issues of underwriting and rating are more complex in Wisconsin than California. California's "tight" rate bands (plus or minus 10 percent from a midpoint rate) allowed the HIPC to adjust rates solely due to geography, family structure, and age, without significant risk of adverse selection. (California does not allow rate adjustments based on gender.) Wisconsin's 30 percent rate bands and additional allowable factors present a greater underwriting/rating challenge. Seek the counsel of a knowledgeable actuary in designing Program standards.
- Market, market, market: Use every possible tool, including the internet, to reach employers, agents and brokers, business associations, chambers of commerce, anyone who can provide a referral.

They pointed to significant market potential: Most small employers can offer only one health plan, but would rather offer their employees choice, for any number of reasons, including different needs among employees and a better competitive position for recruiting and retaining employees. PBGH staff also noted that PacAdvantage retention rates are extremely high. Once employers offer employees a choice of health plans, they are reluctant to return to providing only one option, as long as premiums remain competitive with the market.

Office staff also interviewed key personnel at Word and Brown, an insurance agency running a successful competitive employee-choice program in California. They provided similar insights. Consultants with the Institute for Health Policy Solutions indicated that these lessons are consistent with successful programs in Colorado and Connecticut.

## 4.0 PRELIMINARY RECOMMENDATIONS

### 4.1 Imminent Budget Shortfall

Appropriations to the Office and the Program administrator in the 1999-2001 budget were intended to fund Program start-up. Ongoing Program funding is to be provided by fees assessed to participating employers as part of their monthly premium.

Current projections indicate that Act 9's administrative appropriation for authorized positions and support will be depleted in March 2001, months before enrollment is sufficient to fund Program operations. Direct Program expenses through November 4, 2000, totaled \$73,400. This figure does not yet include the time of non-Office Department staff for such services as legal counsel, accounting support, and supervision, which must, by law, be charged back to the Office's budget. (Please see Section 1.3 for a discussion of the effects of placement of the Program within the Department.)

The Department will prepare a request for additional resources for submission to the Joint Committee on Finance pursuant to s. 13.10, Wis. Stats.

### 4.2 Inconsistent Requirements Jeopardize Health Plan Participation

In developing the Program, the Board and staff must reconcile two competing goals:

- To design, implement and operate an actuarially sound, financially viable purchasing pool for small businesses; and
- To reduce or stabilize rates for currently insured businesses and provide health insurance coverage for those who are currently uninsured.

As mentioned earlier in this report, purchasing pools and the health plans which choose to participate in them are put at a competitive and risk-selection disadvantage when required to operate under less restrictive participation requirements, underwriting guidelines or rating rules than exist in the outside market. It is critical that health insurers offering coverage both inside and outside of the Program be subject to comparable market rules.

**In all likelihood, if health plans perceive that the Program offers coverage on a more generous basis than the market at large, their justifiable concerns about adverse selection will prevent them from participating.** Additional health plan filings with the Office of the Commissioner of Insurance (OCI) may also be required if standards are not uniform; this administrative burden must be minimized to the greatest extent possible, to encourage health plan participation.

Several requirements of Act 9 are inconsistent with existing health insurance regulations and/or current market practice. If the Board finds that these inconsistencies prevent health plan participation, the Board may propose language to change the statute, either to refer to statutory provisions applicable to the entire market or to provide the Board more latitude to respond to market conditions. These areas are likely to include:

- The definition of "employer" in s. 40.98(1)(d).
- Employer participation requirements in s. 40.98(3)(a) and 40.98(3)(b).
- The requirement in s. 40.98(5) that health plans participating in the Program extend to employers with more than 50 employees guaranteed issue

protections currently only applicable to employers with 2-50 employees (under Ch. 635, Wis. Stats.).

Other inconsistencies that have been brought to the Board's attention and may warrant further consideration include:

- The requirement in s. 40.98(6)(d) to disclose agent commissions on the front page of Program policies. In the absence of such a requirement for all health insurance policies market-wide, this provision could cause concern among the agent/broker community because this will be the only program where their payments are so visible.
- The language in s. 40.98(2)(bm), which may create additional OCI filing burdens and plan redesigns.

### 4.3 Other Considerations

The Board is hopeful that the newly-appointed task force chaired by Insurance Commissioner O'Connell will consider changes to current underlying health insurance regulations which would create an environment more favorable to the Program. The Board is not taking a position regarding any of the following issues, but wishes to stimulate discussion and thought. The following list should be considered illustrative, not exhaustive.

- Full disclosure of plan design options: Several states require health plans and their agents to disclose to each prospective small employer group *all* plan design options for which that group is qualified. Over time, this provision streamlines plan offerings, simplifies comparisons between insurers, and reduces confusion for small business decision-makers.
- Modification of mandatory benefit requirements: Currently, Wisconsin law requires that all health insurance policies cover a host of specific treatments and providers. Self-insured employers are exempt from these "mandated inclusion" provisions pursuant to ERISA (the 1974 Employee Retirement and Income Security Act). Requiring insurers to offer these coverages as *options* and/or allowing insurers to offer mandate-free policies returns the choice of providing specific coverages to the employer. This is likely to reduce premium costs, especially for small businesses, which can least afford the financial risk of self-insurance, and may encourage small businesses not currently offering insurance to do so.
- Tighter rate bands: Current Wisconsin law allows health insurers to vary rates by as much as 30 percent above or below their midpoint rate for a specific policy, based on the health status or claims experience of a particular small employer group. Tightening this range, to 20 percent, 10 percent, or even eliminating the use of health status/claims experience in setting rates (while continuing to allow the use of other factors such as age, sex and geography), would enhance the Program's ability to compete.
- Standard age categories: California statute specifies the age categories by which health insurance rates may vary for small businesses. Of necessity, the PEHCCP will standardize age categories across all participating insurance companies; an industry-wide standard would simplify that process and virtually eliminate the opportunity for unfair competition based on age categories.

- Industry-wide reinsurance of high-risk groups and individuals: This alternative to the Health Insurance Risk-Sharing Program (HIRSP) would allow health insurers to cede responsibility for specific high-risk groups and individuals when they first enroll to a re-insurance pool funded via a mechanism similar to HIRSP's. The greatest advantage of this approach is its transparency to employers and employees: They remain in the health plan they select and are not even aware that the risk shift has taken place. Such a mechanism could increase the likelihood of health plan participation in the Program, facilitate simpler underwriting and rating guidelines within the pool, and reduce the risk of adverse selection in comparison to the outside market.

## ATTACHMENT A: HEALTH PLANS OFFERED TO STATE EMPLOYEES

### KEY:

A	Atrium Health Plan
C	CompcareBlue—Southeast
C-NE	CompcareBlue—Northeast
C-NW	CompcareBlue—Northwest
C-N	CompcareBlue—Northwoods
D	Dean Health Plan
GEC	Group Health Cooperative of Eau Claire
GSC	Group Health Cooperative of South Central Wisconsin
GL	Gundersen Lutheran Health Plan
HE	Humana—Eastern
HW	Humana—Western
L	LaCrosseCarePlus
MA	Medical Associates Health Plan
MC	MercyCare Health Plan
N-F	Network Health Plan—Fox Valley
PP	Physicians Plus Insurance Corp—South Central
P	Prevea Health Plan
S	Security Health Plan of Wisconsin, Inc.
T	Touchpoint Health Plan
UC	Unity Health Plans—Community Network
UU	Unity Health Plans—UW Health
V	Valley Health Plan

Source: "It's Your Choice 2001," published by the Department of Employee Trust Funds.

**PLEASE NOTE:** This map has been modified slightly. The designation "SMP" has been removed from each county in which it originally appeared. The State Maintenance Plan (SMP) is a self-funded option available only to employees of the state and participating local governments. By law, it cannot be made available to PEHCCP participants.

## **ATTACHMENT B: STAFF BIOGRAPHIES**

### **Thomas Korpady, Administrator**

Thomas Korpady, Administrator of the Division of Insurance Services, has extensive knowledge and experience in public-sector health care policy and program development. In hiring the Office's Director and Program Manager, he sought and found individuals with complementary backgrounds in the private sector.

### **Phillip Borden, Director**

Phillip Borden, Director, has twelve years of experience in the evaluation, placement, implementation, and communication of group health benefits. Prior to joining the Department, he was a Senior Consultant and Director of National Accounts for a major national managed care organization in Milwaukee. Mr. Borden holds a Bachelor of Business Administration degree from the University of Wisconsin–Stout and the designation of Certified Employee Benefits Specialist through the International Foundation of Employee Benefit Plans and the Wharton Business School.

### **A.B. Orlik, Program Manager**

A.B. Orlik, Program Manager, brings to the Office ten years of experience in health benefits, from reviewing benefit plan booklets to advising state and national policy-makers. In the last four years, she has focused her attention on group health insurance purchasing arrangements like the PEHCCP. She served on the team which developed and marketed a small employer purchasing pool in south-central Wisconsin, known as A-CHIP (The Alliance-Chamber Health Insurance Program). In that capacity she built strong relationships with area chambers of commerce, local independent insurance agents, and other purchasing coalitions across the country. Ms. Orlik holds a degree in Secondary Education from the University of Wisconsin–Madison.

### **Additional Staff**

The Office is also staffed by a half-time Board Coordinator, Gina Fischer. It is not anticipated that the Office's remaining full-time position of Program Assistant will be filled until after January 1, 2001.